Chief Psychiatrist's Community of Practice

Part 3 - Eating Disorders: Question and Answer - clinicians and lived experience

Acknowledgement of Country

I would like to acknowledge the Traditional Custodians of the lands on which each of us is meeting today, throughout Western Australia, for us here in Perth the Whadjuk Nyoongar people, here in the season of Kambarang. I pay my respects to their Elders past and present.

Welcome - Dr Nathan Gibson, Chief Psychiatrist

These sessions have been intended to be for clinicians, by clinicians. I thank Dr Lisa Miller, Fintan O'Looney, Clinical Nurse Specialist, from WA Eating Disorders Outreach Consultation Service (WAEDOCS), and Shannon Calvert Lived Experience Advocate and Educator for leading this informative 3-part series which have been so well-received.

The value of bringing all perspectives together is clear – the clinical, lived experience and legal –provide a more holistic discussion and a realistic perspective on improving care.

- Part 1 focussed on decision-making in eating disorders and highlighted the importance of timely treatment, compassionate and firm boundaries, and challenges with recovery conversations at that acute stage.
- Part 2 covered understanding risks in co-occurring needs and complexities. Presentations explained the dynamic spectrum of eating disorders, the interplay between co-morbidities such as attention-deficit/hyperactivity disorder and autism spectrum disorders, and that trauma is often a contributing factor.

The Inspector of Custodial Services has also mentioned, today, the influence of trauma at the Banksia Hill Juvenile Detention Centre, which reinforces the importance of the consideration of trauma across a range of contexts.

This is our last session for the 2022, we hope you've found them useful. To assist planning for 2023 please complete the survey: **Community of Practice Survey 2023:** https://redcap.link/vcojjmil

Dr Nathan Gibson, Chief Psychiatrist

Recognition of Lived Experience

I would like to recognise the contributions of Lived Experience leaders- their courage to share their voice, knowledge and expertise for clinicians, families, and consumers to learn from and to seek change. Whether it's Grace Tame at the WAAMH conference or here with Shannon, we recognise the courage to share your voice with us.

Juliette Stevens, Principal Officer Reviews/ Facilitator

Key Messages

Trust starts with a well-communicated care plan. The care plan brings everyone together, communicates the plan in a clear and transparent way, clarifies responsibilities and is the **supportive foundation** in a context of uncertainty.

Start your discharge planning process at the start of the admission. It helps to reflect on the individual's progress.

Consistency and collaboration are important across the continuum of care and transitions to develop trust**.**

Proactive and place-based collaboration in rural and remote areas can provide an excellent continuum of care, by the teams available across health and community services, especially for young people.

Specialised peer support in eating disorders continues to develop. Capacity-building is needed across the sector.

Community Treatment Orders can, at times, assist in providing structure to continue progress for someone with a primary eating disorder who has struggled to break the cycle of starvation and readmission. **But CTOs may become problematic in those with more complex / trans-diagnostic presentations** in which medicalisation of distress signalling can be inadvertently reinforced.

Question: What does good care co-ordination with an eating disordered client look like in your experience?

Fundamentally it's integration and communication across the treatment spectrum. From primary care to community mental health teams to private clinicians like dietitians, clinical psychologists, and in general medical settings.

Consistency and cohesiveness across the continuum. The individual at the centre then feels contained and supported. Only then, can the opportunity to rebuild an identity outside of the illness begin. Driving the need for consistency has helped to reduce people falling through the cracks between teams which was frequent in the past.

Accountability of the person over their own treatment and recovery. This needs to be as **collaborative** as possible to allow for the highest chance of the individual recovering. Acknowledge that every person's needs differ.

Care planning brings everyone together to communicate the plan, inclusive of the person with living experience, their community whether it's carer, family or kin– even when the person might not have capacity at the time.

- Also, a care plan with the multidisciplinary team allows the individual to be more inclusive of others in the team who may not have been involved previously, for example during an inpatient admission.

Ownership of progress: Even if the person is not ready for recovery conversations, a care plan is an opportunity for personal agency - to be involved in difficult decisions. It plants the seeds for skills and capacity towards recovery.

"I would recommend care plans for anyone that has an inpatient experience with an eating disorder, or mental ill health, to start discharge planning at the start of admission…. many people with eating disorders have a significant trust deficit around who to trust and what to trust…. So, I think it (the care plan) lays an essential and supportive foundation for all involved."

Shannon Calvert, Lived Experience

Question: How can I support someone with an eating disorder to access peer support? *WA Country Health Service*

Shannon Calvert: Peer support is an important opportunity for our sector moving forward. There are limited peer workers specialised in eating disorders however this is a work in progress. There are many community services offering peer support to people with mental health challenges and co-occurring eating disorder - explore what they have available to offer support in the community.

- Capacity-building for those peer workers, for example, providing training in meal support, is needed.

Policy progress in the development of a Peer Workforce:

- WA Lived Experience (Peer) Workforce Framework (2022) co-designed, WA Mental Health Commission
- National Lived Experience (Peer) Workforce Development Guidelines (2021), includes resources to assist in developing the Lived Experience workforce and a variety of roles (National Mental Health Commission).

Question: Accessing inpatient eating disorder care for regional patients seems difficult and they don't always get the required treatment in regional hospitals. How can this need be met in the regions? *(WACHS)*

Dr Lisa Miller:

- **Currently, there are no specialist inpatient beds for people with eating disorders anywhere in the State** – both in the child and adolescent, and in the adult sector**.** So, access to inpatient care anywhere remains challenging.
- Acute medical beds and their consultation liaison psychiatry services currently provide support, or via Perth Children's Hospital eating disorders program, to make use of available beds. This is not the same as a comprehensive specialist inpatient eating disorders unit and there is clear evidence to support their value.

- Equally, we need move away from the idea that, if we just send this person from this regional or remote area to Perth, and 'all of the expertise is there', their eating disorder will be fixed.

> *"WAEDOCS has had great success in supporting many regional and country centres… supporting young people with eating disorders closer to home, closer to family, and because sometimes smaller systems are easier to affect cultural change in than big complex systems.". Dr Lisa Miller*

Bunbury Example – Collaboration for better access and a better continuum of care

Previously, challenges in accessing support for people with eating disorders in Bunbury led to ministerial questions due to people needing to come to Perth or even inter-state, for care. This has now changed.

Dr Lisa Miller: The Bunbury Team deserve recognition due to their impressive collaboration between general medical staff, the liaison team, psychiatry, community mental health services and dieticians which developed over a 2-year-period. Arguably, they now offer a more **comprehensive continuum of care** than anywhere else in the public sector currently, due to the relationship building and integration of care between services at points of transition.

> *"The physician down there, Esther Knight-Terlouw, said: "Lisa it just felt for a long time like we were pulling in opposite directions, but what we were able to do is collaborate … and we got better care for our patients in a shorter period of time.". It just felt much more rewarding as clinicians.". Dr Lisa Miller*

Dr Nathan Gibson: Whilst specialist beds are not being built currently, it is recognised that embedding models of care in older units can be challenging. It is a priority of our Office, from a planning perspective, that across all new units being built, the needs of people with eating disorders are planned for, right from the outset.

Question: Contagion, youth and the inpatient setting – is it a known issue, and how do you manage it?

The panel discussed the issue of contagion as summarised below:

- Literature on the topic of contagion is limited.
- The driving factors for youth are mutual peer influence, group cohesion – the need to belong.
- Social media use has increased over the past 10 years with 'Pro-Ana' /Pro-Mia" sites (pro- anorexia and pro-bulimia) however, some people are anti-eating disorder behaviour-culture even if they have an eating disorder.
- Due to intensive fear, shame guilt, the sense of belonging that comes with being part of a community is attractive for young people, due to maturity, even if the culture is potentially harmful.

In an inpatient setting, recognise that there might be different reasons for each person as to why they are stopping eating. Step back to look at what is happening for the individual and for those around them – caution generalisation.

On help-eliciting behaviour: *"If as a system we speak that medicalised criteria-driven language: "The more medically unwell you are – the more likely we are to listen and validate your concern.' that is a problem.". Dr Lisa Miller*

Question: Community Treatment Orders (CTOs) – when are they helpful and unhelpful?

- CTOs can be useful for people with regular admissions, perhaps who have been life-threateningly unwell, for traction to continue progress made in an inpatient setting and to prevent decline outside this structured setting.
- CTOs can help people re-engage with their identity, quality of life and personal goals outside the eating disorder.
- CTOs don't tend to work well where the primary diagnosis is not their eating disorder. Attachment vulnerability, or emotional dysregulation, where leaning-in to the eating disorder becomes a mechanism for signalling distress.
- From a Lived Experience perspective, people with eating disorders may find CTOs punitive. However, it's how we communicate about the CTOs, as part of a care plan towards recovery and support the team implementing them.

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